

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027745
STATE FILE NUMBER

FILED AUG 11 1958 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1976

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton, Richmond Heights		c. CITY OR TOWN St. Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Marys Hosp.		d. STREET ADDRESS 4704 Varrelman	
3. NAME OF DECEASED (Type or print) KATHLEEN LOUISE RODERICK		4. DATE OF DEATH July 26, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) Clayton, Mo.
13a. FATHER'S NAME Leonard Roderick		13b. MOTHER'S MAIDEN NAME Catherine Fussner	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address Leonard Roderick-4704 Varrelman
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, pulmonary, bilateral Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Prematurity - 6 1/2 mo gest. DUE TO (c) 7625			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 7/24/58 to 7/24/58 and last saw her alive on 7/25/58 Death occurred on 7/24/58 at 12:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Kay v. Boedeker M.D.		22b. ADDRESS 100 N. Euclid	22c. DATE SIGNED 7/26/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 28, 1958	23c. NAME OF CEMETERY OR CREMATORY St Matthews	23d. LOCATION (City, town, or county) St. Louis, Mo.
24. FUNERAL DIRECTOR Kriegshauser-4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. 7-28-58	26. REGISTRAR'S SIGNATURE Deibert R. Dornke M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard W. Storr

Licensed Embalmer No. 4007

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.